

The Nectar of Your Endoscopic Spirit

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"There is no education like adversity."

--Disraeli

Serving as president of the Society of Laparoendoscopic Surgeons has indeed been an honor and a privilege. I'd like to thank the members of the Society, all 5,950, who allowed me to represent them; and I would like to thank my wife, Becky Hunt, the mother of our two children and a busy radiologist, for her support, without which I would not have been able to accomplish what I have over the past decade. I'd like also to thank the Board, first for putting their trust in me, and, second, for finally having our annual meeting out west. It's taken seven long years, but we're finally here. I think it is particularly apropos that the Society has a western president during its first venture in this part of the country. As Dr. Kavic pointed out in his gracious introduction, I'm a true westerner. I also believe that we, the endoscopists of the nineties, are all "cowboys" in a metaphoric sense. We have truly been practicing in the frontier days of operative laparoscopy. So, in recognition of these unique circumstances, I thought I'd add a little western flair to my portion of the program.

When I sat down to gather my thoughts on today's address, I envisioned myself standing here before general surgeons, gynecologists, urologists, thoracic surgeons, oncologists, private practitioners, academicians, North Americans, Europeans, Asians, South Americans . . . the best and the brightest that the field of endoscopy has to offer, from the local level to the international level. And I thought, What can I share with this eclectic group? What profound message can I impart to this diverse, prestigious organization? Presidential addresses, after all, should be marked by great intellectual insight and depth, and unfortunately I'm following last year's outstanding address by

Dr. Kavic. Yet, as I pondered most past presidential addresses, I realized that, of the couple of dozen or so that I had sat through in the past decade, most were simply forgotten formalities. My enthusiasm waned and my mind froze when I realized that potentially I was faced with the onerous task of creating a profound, forgotten formality—not what I had envisioned for us today. The western saying, "shallow rivers and shallow minds freeze first," kind of sums up the creative energy I started with. My mind was frozen!

I thought I might "thaw the ice" a little by gathering up every published presidential address given to a prestigious surgical society in the past 50 years. Now, don't get me wrong. I wasn't perusing the literature to steal ideas. With a frozen mind like mine, I was looking to plagiarize the entire speech! With my homework accomplished, I had quite a selection of presidential addresses to choose from. I categorized them in order to help me choose MY address. There were 63 historical talks, 78 philosophical addresses, and 49 clinical presentations. It was clear, when I analyzed this data, that there was no statistically significant difference in the success of any of these topics. This only added to my frustration, but as I thought more about it my cerebral juices began to thaw and some quirky ideas came to mind. I jotted down my thoughts and ran them past my colleague, Earl Surwit, who is not only a colleague, but my partner, friend, and mentor. Earl and I have bounced ideas off one another for years. In fact, it was only through this teamwork that we were able to achieve all we accomplished in laparoscopy over the last several years.

Earl agreed with my overall assessment of "The Presidential Address," ie, a profound forgotten formality, and in his commiseration offered four options: 1) suicide; 2) feign illness on the day of the meeting; 3) a speech writer; or 4) do what you want. Since my laparoscopic career up to this point had been one of blazing new trails

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instead of following old wagon tracks, I decided to blaze new trails once again. Earl agreed to be the sounding board for my presidential address concepts, which translates to keeping me from making a complete fool of myself. Although my goals were lofty, we both knew that “profound and riveting” were most likely out of reach. While I was aspiring to “memorable and enlightening,” Earl was just hoping that coffee would be served immediately before my address and that the house lights would remain on while I spoke.

What I originally conjured up was to share my thoughts with you by telling a story. I had several ideas for storylines. Now, I really love Greek mythology, so my first idea revolved around the little-known Greek goddess, Endoskopia (**Figure 1**). To my chagrin, Earl was less than crazy about Endoskopia—and the whole storyline concept for that matter—so I spared him the details about my next idea, based on a new hit TV show, “L.A. Laparoscopists,” starring Nick Multiport and Mini Clipper. Next, I thought about sharing with you the story of our journey of laparoscopy in GYN oncology, but frankly speaking, the only person who would be interested in this is my mother, and she’s not here today. What I needed was a topic that would capture the interest of the broad spectrum of the members of the SLS: gynecologists, general surgeons, thoracic surgeons, urologists. To make the challenge even more formidable, this distinguished audience covers the gamut from hard-working, busy private practitioners to recognized national and international experts and authors.

I thought, What do I have in common with this group? Well, first, I’m currently in a busy private practice, so I know the lives many of you lead. I work closely with urologists and general surgeons, and in fact I have operated on many male patients—certainly an oddity among gynecologists. And my experience in academics with publishing and national and international travel has given me great insight into the lives of many of you here today, as well. What are the common threads that connect us all? Where have we been and where are we going? What did it take to get this far, and what will it take in the future? Certainly hard work, perseverance, creativity . . . and one very important element that is not often mentioned: overcoming adversity.

Thanks to laparoscopy, it’s a subject I am very familiar with. One of the first things I learned from the oncologists, the vaginal surgeons, and the academicians was that laparoscopists weren’t their favorite group of innovators.



Figure 1. Greek Goddess Endoskopia.

Adversity is something I have experienced at every level—local, national, and international. I remember as though it were yesterday some of my first international presentations, the derogatory remarks from the floor microphone by the naysayers and nonbelievers, who knew little about laparoscopy but also happened to be well respected European professors in oncology and gynecology; my national experiences with comments at major meetings by American professors who, again, knew little about laparoscopy but felt our work was “concerning” and “disturbing”; my frustration, even after having managed over 100 oncologic patients laparoscopically, of trying to convince my boss, the chief of Gynecologic Oncology, that investigating laparoscopy in oncology was legitimate. And, while gynecologists had no problem radically changing their surgical management of some cancers (vulvar cancer, for example) based on common sense and intuition, I can’t tell you how often I heard, “You need a multi-institutional, randomized, prospective study.” To me, not only did it not make sense, but it wasn’t even appropriate.

It wasn’t just me. I remember Jordan Phillips, the renowned American organizer and educator of gynecologic laparoscopy, past SLS Excel Award winner, telling me that in early years his hospital was so opposed to laparoscopy they refused to buy laparoscopic equipment for him. He had to buy it himself. And that a major gynecologic surgical textbook during those early times buried

laparoscopy in the United States for a number of years when its leading author wrote that he “tried laparoscopy, couldn’t see a thing,” and felt it was a useless technique.

Some of you here today remember when culdoscopy was the only way to view the pelvis endoscopically. I remember Melvin Cohen, the well-known early advocate of laparoscopy in this country, sharing with me the difficulties he met in converting gynecologists from culdoscopy to laparoscopy, and the painful public debates he had with his mentor, a general surgeon and culdoscopic advocate, Dr. Albert Decker. Dr. Cohen was so affected by this conflict that he wrote in the preface of his textbook on laparoscopy, “I wish also to honor my good friend Albert Decker, MD, the ‘father of culdoscopy.’ It is my hope that despite the current enthusiasm for laparoscopy, culdoscopy will continue to be taught and performed at medical centers.”

Harry Hasson, the father of open laparoscopy and inventor of the Hasson cannula, had similar experiences. The chief of his department wouldn’t allow him to perform his laparoscopic procedures in their hospital. So he had to obtain privileges at Grant Hospital there in Chicago, buy his own laparoscopic equipment and instruments, and accomplish his goals despite his adversaries. Around that same time, Jerry Hulka, a past Society of Laparoscopic Surgeons Excel Award recipient, an early pioneer in laparoscopy and laparoscopic tubal sterilization, tried to introduce laparoscopy to the department of obstetrics and gynecology at the University of North Carolina. Staff members were opposed to this “interesting curiosity from Europe,” because they felt it had no promise and that the University of North Carolina should not waste their time pursuing it. Residents there were also vehemently opposed, because they wouldn’t get to do the exploratory laparotomies they felt they desperately needed to do. Yet, within a few years, Dr. Hulka and the University of North Carolina were leading pioneers in the development of laparoscopic surgery in the United States.

Americans weren’t the only laparoscopists faced with adversity. I recall Victor Gomel, the renowned Canadian pioneer of microsurgery and laparoscopy in reproductive medicine, sharing with me a similar experience. In 1972, he used a laparoscope to confirm an ectopic pregnancy in one of his young patients. Intraoperatively he made the decision to attempt to manage it laparoscopically, and so performed the world’s first laparoscopic segmental excision for a tubal pregnancy. He was joyous and couldn’t

wait to publish and share his experience with the rest of the world. But his elation was quickly deflated the following day when his boss told him that not only would he not publish this experience, but if he ever performed the operation again he would be fired. Professor Gomel wrote in the preface of the first edition of his book, *Microsurgery in Female Infertility*, “This work started in the late 1960s, when within our specialty, microsurgery and laparoscopy, we were viewed with skepticism and even ridicule.”

Patrick Steptoe, the renowned British laparoscopist, author of the first English language textbook on laparoscopy and an early proponent of laparoscopic sterilization, had an honorary professorship at a prestigious American institution stripped from him when he used the laparoscope to retrieve the egg from Lesley Brown, mother of the world’s first “test-tube baby.” Kurt Semm, the father of operative laparoscopy, the first to perform a laparoscopic appendectomy, oophorectomy, and myomectomy, a past Excel Award recipient, inventor of the automatic insufflator, the endocoagulator, the laparoscopic slipknot, and a multitude of other laparoscopic instruments, was forced to have a CT scan of his head to rule out organic sources for his “ludicrous pursuits.” Grzegorz Litynsky, in his book *Highlights in the History of Laparoscopy*, notes that after Kurt Semm performed his first laparoscopic appendectomy in 1980, he received the worst criticism of his career. “Both surgeons and gynecologists were angry at me. All my initial attempts to publish on the laparoscopic appendectomy were refused, with the comment that such nonsense does not and will never belong to general surgery.” Semm notes that his work also was not well received by gynecologists. Once, during a lecture on laparoscopic myomectomy, someone interrupted his talk by pulling the projector plug and saying, “We are scientists, make a note of that.”

General surgeons have faced similar adversity and ridicule. Eddie Joe Reddick, an early proponent and pioneer of laparoscopic cholecystectomy in the United States, and a past Excel Award winner, shared with me his greatest adversity, coming from where he least expected it: academicians and teaching chiefs of surgery in the United States. “They wrote it off as a passing fad initially.” Then after many physicians in this country, including himself, had performed more than 150 laparoscopic cholecystectomies, the academicians claimed it was worthy of study but should not be done by others until they had a chance to study it, according to Reddick. This skepticism and

reluctance from a group of people who should have been the most open-minded and supportive was unbelievable. He was essentially ostracized by a segment of the academic community, first because they felt threatened by his work, and then evoked envy. To this day, Eddie Jo Reddick has not been invited to speak to or participate in any of the American College of Surgeons' meetings or teaching courses. One can only wonder what adversities this year's Excel Award winners, Bill Saye and Barry McKernan, have experienced in their careers as laparoscopists.

It occurred to me that it wasn't just the internationally recognized pioneers who suffered, but their disciples, as well. I could recall local surgeons being the brunt of jokes when their initial laparoscopic cholecystectomies and hysterectomies were time-consuming, when their first splenectomies and funduplications were dubbed "foreveroscopies"; the nurses and anesthesiologists commenting behind their backs about the "special gloves" that some laparoscopists needed—"the ones with ten thumbs."

Adversity to the advancement of endoscopy is the one thing that our predecessors faced and which every doctor in this room already has or is likely to encounter, whether from local, national, personal, public, or academic corners, and coming from any number of factions: nurses, peers, friends, enemies, endoscopists and nonendoscopists, superiors, even industry. Harry Hasson and Jerry Hulka independently pointed out to me that one of the biggest adversities faced by gynecologic endoscopists today comes from medical payors. Until recently, reimbursement levels for laparoscopic gynecologic procedures were lower than for the same procedures performed via laparotomy. Hulka and Reich dedicate Appendix A of the third edition of their *Textbook on Laparoscopy* to this very issue.

It seems ludicrous that endoscopic surgeons use their own time and money to learn a new surgical technique that benefits patients, society, and insurance companies—and the result is a pay cut. This substantial endoscopic adversity stems from prejudice: "A big operation requires a big incision."

Every endoscopist in this room should confront adversity as our predecessors did. Like them, my experiences with adversity have actually fueled, strengthened, and matured my laparoscopic spirit. It fueled my spirit by acting as a catalyst. It spurred me on to succeed. It strengthened my spirit the way a strong wind makes a stronger tree. And it matured my laparoscopic spirit by educating me. I learned to defend myself by good, scientific proof. "Suspicion ain't proof." I learned not to be a laparoscopic zealot. I learned that there are boundaries and limitations. I learned not to be driven by fear, not to shrink from the naysayers, but to be confident enough to face difficult opposition and keep going.

All of you here today are pioneers and disciples of operative endoscopy. You are all "cowboys," exploring new frontiers that will enrich and improve the lives of the patients you treat. In your researching, developing, and acquiring new skills, you will find yourself facing adversity. It is simply unavoidable—and well it should be, because the absence of adversity would be the greater disaster. I believe that to make worthwhile changes, adversity must be encountered and conquered. In other words, if you want to see the rainbow, you gotta put up with the rain. So, take some risks but expect adversity—in fact, welcome it—and treat it as a blessing, not a problem. As the great Greek goddess Endoskopia once said, "Adversity is the nectar that fuels, strengthens, and nurtures your endoscopic spirit."